WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

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ORIGINAL: ENGLISH

ORGANIZATION OF PRIMARY HEALTH CARE IN COMMUNITIES

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Contents

CHAPTER 1 - INTRODUCTION

This document is concerned with the implementation of primary health care. Its purpose is to promote an understanding of what is involved in the organization of PHC in communities. It is intended to assist those personally involved in the promotion, planning and development of PHC. Such persons may be policy makers, planners or health service managers at national level. Just as importantly they may be personnel at intermediate and local levels who actually spend at least part of their time in contact with communities. They may be government employees or not, from the health sector or from any of the other essential sectors engaged in community development. Hopefully they may also be interested members of communities themselves.

1.1 The Alma Ata Declaration

The Alma Ata Conference which in 1978 formally launched primary health care as the main thrust and focus for the promotion of world health established the following definition:-

> "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part both of the country's health system, of which it is the central junction and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

This definition forms an important part of the Declaration of Alma Ata and is the basis of understanding for what is known as the PHC approach. The Declaration was formally adopted by representatives of 134 governments thus committing them to the development of primary health care.

Within this definition there are a number of different components. These are PHC as a philosophy, PHC as a strategy and PHC as a level of health care as well as a recommended list of eight essential elements which define the basic areas for action in a PHC system. PHC is a combination of all four components.

Although it is beyond the scope of this document to explore each of these components in detail, nevertheless the following paragraphs are included in order to promote a deeper understanding of the totality of PHC.

1.2 The PHC philosophy.

The PHC philosophy incorporates certain fundamental values common to the overall process of development but receiving fresh emphasis in the field of health. These are:-

1.2.1 Health is fundamentally related to availability and distribution of resources - not just health resources such as doctors, nurses, clinics, medicines, but also other socio-economic resources such as education, water supply and food supply. Therefore PHC is concerned with equity to ensure that available health and social resources are distributed justly with due consideration for those whose needs are greatest.

1.2.2 Health is an integral part of overall development. Thus factors which influence health are social, cultural and economic as well as biological and environmental.

1.2.3 Achievement of better health requires much more involvement by people themselves as individuals, families and communities, in taking action on their own behalf by adopting healthy behaviour and ensuring a healthy environment. Self reliance, separate from and additional to the contributions of conventional health services, is required to a much greater extent.

1.3 The PHC Strategy.

The PHC strategy incorporates the values expressed in the PHC philosophy as follows:-

1.3.1 The need for change in the health care system.

PHC is concerned with establishing a system which meets the essential needs of the majority. Thus PHC aims to achieve full coverage with essential health care by distributing resources in order to obtain maximum benefit for the people as a whole at the lowest cost. This implies that allocation of resources will be carried out according to health needs.

In contrast the existing systems in many countries achieve a limited coverage of only a proportion of the population, usually those in urban areas, through a hospital based system which provides relatively sophisticated and costly care.

1.3.2 Intersectoral action for health.

Health is one component of community development. The PHC strategy seeks to make health a high priority in the overall development process by creating awareness in society as a whole of the factors contributing to health and disease and of the potential of non-health sectors to contribute to better health through intersectoral action.

1.3.3 Individual and collective responsibility for health.

PHC is concerned with the promotion of individual and community responsibility for health as an essential complement to the health system. In order to achieve this two actions are needed.

The first is for governments to facilitate more community involvement in decision-making. This is a political issue.

The second is to inform people of their potential for acquiring better health through their own efforts. This involves not only the adoption of certain behaviour and styles of living but also the building up of a system of organisation and decision-making at local level to identify and tackle local health problems.

1.4 PHC as a level of health care

Conventionally the term primary care has been used to refer to the most peripheral level of the health system, the level to be contacted first by the public when seeking treatment. This includes such institutions as health centres, clinics, sub-centres, dispensaries, general practitioners' offices and polyclinics, the names varying from country to country.

However the PHC approach stresses that the first level of health care not only stretches beyond the conventional system as described above but actually begins with community activities. These may include activities by the community as a whole, by families for their own benefit and even activities by individuals through self-care.

Since PHC refers to provision of essential care made available and accessible to everyone it is necessary for individual countries to define what is meant by essential care. This will include a decision on whether PHC includes only the institutions at local level such as health centres and clinics or whether it also includes the first level hospitals.

1.5 The essential elements

The Alma Ata Conference drew up the following list of essential elements in order to define the minimum services necessary for achieving health for all. These are:-

- education concerning prevailing health problems,
- promotion of food supply and proper nutrition,
- adequate supply of safe water and basic sanitation,
- maternal and child health, including family planning,
- immunisation against the major infectious diseases,
- prevention and control of locally endemic diseases,
- appropriate treatment of common diseases and injuries,
- provision of essential drugs.

While this is a useful guiding list it does not constitute a definition and it is evident that the totality of PHC is only adequately explained in the terms of all four components described above.

By including an analysis of the meaning of PHC in the introductory chapter it is intended to set the scene as clearly and unambiguously as possible for the topic of this document - the organisation of PHC in communities. This is the most crucial of all PHC issues. By promoting an understanding of the processes involved in organising PHC in communities it is intended that the document will contribute to the efforts by countries to establish a PHC system.

The contents are divided into two sections. The first, consisting of chapters 2 to 7 describes the processes entailed in establishing effective community involvement.

The second section, which includes chapters 8 to 10, describes the kind of support which is necessary to enable community involvement to function. This includes not only support from local health workers and personnel from other sectors of community development but also intermediate and national level support.

The document as a whole is intended to address the situations which exist in many less developed countries. Therefore the references made are mainly, but not exclusively, to countries which are less developed.

CHAPTER 2. COMMUNITY ORGANIZATION FOR IMPLEMENTING PRIMARY HEALTH CASE

Implementation of PHC needs active community involvement. To be really effective the involvement should become a permanent feature of community life and should include as many people as possible in sustained health activities. This will require a mechanism for community organisation to be established.

2.1 Features of a community

The term community is often used to describe a group of people living together within a certain geographical area. This is a gross over-simplification. In defining a community one must also take account of the many factors which explain WHY people live together. These include ethnic origin, family ties, cultural background, religious beliefs, political beliefs, class, caste and economic status.

Those, such as staff from local health institutions, whose task is to promote PHC must be very sensitive to these factors when stimulating communities to establish a mechanism for organising their health activities.

The most successful action is likely to stem from a group of people who share positive assets such as common values, common goals and a willingness to work together to achieve them. Groups divided by conflict and negative features such as wide disparities in income and the exercise of power on behalf of a minority, are unlikely to achieve much. Whilst it is not practically possible to divide populations in order to form communities with only positive assets nevertheless it may be possible to minimise the impact of negative aspects, provided these are identified. For example, in a large population group, such as a big village or a section of a town, it may be possible to promote separate organisation and separate Community Health Workers for groups who cannot work together.

However in small population settlements there will usually be no practical alternative other than to deal with the people as an entity. In these circumstances the best approach for the health worker may be to identify those whose needs are greatest and to try to ensure that their needs are met.

2.2 Social structure of communities

One of the implications of community involvement in PHC is that the mechanism for organisation and decision making will stem from the people themselves and it is they who will assume responsibility for maintaining its effectiveness. However if personnel from the health system, particularly those from the local health institution, are to play their roles as technical advisers, educators and motivators they must acquire a thorough knowledge of the ways in which communities organise themselves for communal living and decision-making.

Insight into a community's mechanism for organisation can be gained by finding out the answers to the following questions:-

Who makes the important decisions?
Whose opinions are valued?
Whose opinions are powerful?

2.2.1 The decision-makers

The decision-makers are the heads of the community. They will vary in type according to the dominant cultural, religious and political forces at work in the community and the country as a whole. Examples are traditional leaders such as village headmen whose positions depend on a mixture of hereditary power stemming from their membership of a "royal" family and selection by members of the village as a whole. In other communities a traditional leader may owe his position to membership of a prestigious religious group such as the Brahmins in Hindu society.

In more politicized societies leadership may be vested in a group of people elected by the community as part of overall national government. In societies with more than one political party leadership may change whenever an election takes place, leading to change of policies and strategies for development.

As far as PHC is concerned the decision makers are the people who must be approached first in the process of making contact with a community. Apart from the importance of their own views they control access to the community as a whole. Their support is essential for the development of PHC.

2.2.2 The respected

All communities include people whose opinions are valued and consulted whenever important decisions have to be taken. It follows that such persons must be identified and informed about PHC as early as possible.

Those whose opinions are respected are usually people who are believed to have more wisdom, experience and knowledge than ordinary members of the community. For example, in many countries the elderly, men and women, are afforded a special place in specific decision making on issues affecting the family and community in view of their years of experience.

Others are respected because they are perceived to have special insight into moral, spiritual or cultural matters such as birth, death, sickness and natural events such as floods, droughts, crop failure. Such people, who include traditional healers and traditional birth attendants, may be regarded as having supernatural or 'god given' wisdom.

Yet others have gained experience of life beyond the community. For example, it is common in many countries for young men in rural areas to travel to the cities or even to other countries in search of employment. Used constructively the experience they have attained may afford them a place of status and influence when they return home.

2.2.3 The powerful

Lastly there are those whose opinions matter because of the strength and power of the person who holds them. These opinions may not be respected by the rest of the community. Indeed they may be deemed to be contrary to the good of the community as a whole. However the community may have no option but to accept such opinions since the holder may be a major local employer, owner of land or lender of money, who is in a position to impose a penalty if his views are disregarded. Such persons may be strongly opposed to the community involvement advocated in the PHC approach, or may pretend to agree only as a strategy to enable them to hold on to their power.

2.3 Possible mechanisms for community organization of PHC

In general terms there are three possible mechanisms for community organisation for PHC.

FIRST, PHC may be organised as an integral part of overall community development using the existing mechanism such as the community development committee, community council, party committee. This has an advantage of integrating health activities with all other development activities and facilitates intersectoral co-operation. It can also be a disadvantage if the existing mechanism is weak or if the leadership is pursuing self-interest as opposed to the interest of the community as a whole.

SECOND, PHC may be organized as a subsidiary of the principal mechanism, for example, as a subcommittee of the main community development committee. This may have an advantage of allowing more time to be spent on PHC issues. However there may be a disadvantage of separating PHC from other community development activities and as a subsidiary there may be a consequent lowering of PHC in the community's development priorities.

THIRD, PHC may be organised through a specific mechanism quite separate from the main development committee. Even more time may be available for PHC but there may also be strong disadvantages such as separation from the principal community decision making body and very

limited possibilities for intersectoral action. There is also a risk that the influence of outsiders such as local health personnel, inadequately prepared in a PHC role, may seriously reduce the extent of community involvement.

It is not possible to select any one of the above as the ideal mechanism for each and every community although there is increasing evidence which favours integration of PHC within the overall community development apparatus. However, since the PHC approach stresses that the community is the critical force it will be a matter for the people to decide what is appropriate for their particular circumstances. The role of the enthusiastic promoter of PHC will be to ensure a clear understanding of PHC and an awareness of their needs amongst the people as well as to point out the advantages and disadvantages of the mechanisms outlined above.

It is important for the promoter of PHC to appreciate that while PHC may be welcomed by a community, health as such may have a lower priority in the minds of the people than activities which directly promote their economic wellbeing such as local industry and agriculture. Therefore it is unreasonable to expect that the time devoted to discussion and decision-making about health will be very substantial. In addition people may not have much time available to devote to discussion such is their burden of labour and such time as exists may be dominated by economic issues.

2.4 Ensuring representation of groups within a community

Achievement of health for all requires that the essential needs of all groups within a community are met. Since community involvement is fundamental to meeting essential needs it follows that representation in decision-making on PHC matters should be broadly based and open to all. However it is a fact that many communities do not wish to give equal representation to certain groups living in their midst. Their reasons may be based on cultural values. For example in many traditional societies women are regarded as an inferior group in spite of their crucial contributions to the survival of the family and community. Other reasons include ethnic, religious and political rivalry particularly if local history recalls open confrontation or conflict.

In such circumstances it may be impossible in the short term to ensure representation of such groups on an equal basis. Even where there may be sympathy towards allowing representation on health matters it may be withheld to avoid setting a precedent which may result in further demands regarded as more threatening to the social structure of the community.

Nevertheless, their views must be represented, if not on their own behalf, then by the health worker, school teacher, religious leader or other respected persons with whom they have frequent contact. In addition it may be possible to organise particular activities as a means of involving them in PHC and meeting their health needs. For example, women's health may be promoted through MCH action, or, more broadly, through the formation of women's clubs.

In circumstances where the denial of representation is persistent and interferes with health development it may be necessary to raise the issue at national level so that corrective action may be taken.

CHAPTER 3. STIMULATING COMMUNITY INVOLVEMENT

In most countries the role of the general public in contributing to health development is not yet readily perceived. Reasons include the fact that health is not afforded a high priority amongst people's development priorities. In addition health is perceived as "an absence of sickness", that is, a passive connotation, accompanying the belief that action to achieve health refers to action by an individual to "do away with" sickness by being treated. In its turn treatment is something to be acquired from someone else - a person with a special gift, or special training and education. This includes both modern and traditional healers.

The possibility of preventing disease by taking particular actions has gained public recognition only relatively recently as the causative agents of particular diseases (for example, infections) have been discovered. Even so the means of prevention, such as vaccination, or destruction of sources of infection, have remained in the hands of specially trained health professionals, such as doctors, nurses, or health inspectors.

The universal acceptance of the PHC approach represents belated recognition of the realities of achieving better health through a combination of prevention of diseases, promotion of good health and treatment of sickness. Nevertheless, its emphasis on community involvement and intersectoral cooperation represents nothing less than a revolutionary change of approach to many of the world's population. With such a background it is understandable that public demand for participation will not be forthcoming without a thorough process of information and education at all levels.

3.1 Making contact with communities

The time of first contact between the health worker and the community is crucial since that is when important first impressions are made. The community, or at least its leaders, may be searching for "the real reason" as opposed to "the declared reason" for a visit from a government representative wishing to discuss community involvement in a health programme. From the community point of view there are grounds for suspicion. If health care is a matter of treating sickness what possibilies exist for community involvement other than to pay out money for medicines or as a contribution towards building a health centre?

Wherever such an understanding of health prevails the premature introduction of the topic of community involvement is best avoided in favour of discussion about local health and development issues leading to a general introduction to the PHC approach.

It is likely that the best person to make initial contact with the community will be someone already sufficiently familiar so as to avoid suspicions such as those described above. A member of staff of the local health centre or hospital may be most suitable. In countries where health institutions and health workers are thinly distributed a local school teacher, community development worker or member of a local women's organisation are possible alternatives.

3.2 Informing communities about PHC

People given responsibility for informing communities about PHC must have certain basic skills and knowledge for which a period of training is an absolute prerequisite.

First and foremost they must be able to communicate with the people, particularly their leaders. This requires great skill in order to convey information in a way that is understood. Equally importantly they must learn how to work with communities to identify their health needs and priorities and how to explain the role of PHC in finding solutions to these problems.

By focussing attention on issues which are of personal importance to members of the community it is likely that they will learn more than through exposure to generalized information. It is the possibility to focus on local issues which makes the personal approach by the individual PHC promoter such a valuable educational tool. However there are other useful means of complementing the information conveyed through personal contact.

One method is to hold preliminary meetings with community representatives, and officials such as members of national assemblies, government officials at intermediate level, and church leaders, whose responsibilities include a number of communities. If such people recognize and accept the importance of PHC they can be powerful advocates in introducing its relevance to individual communities.

Another important means of conveying information is the national and local media. Information distributed in this way enables people to discuss amongst themselves free from the presence of an outsider who may inadvertently inhibit complete freedom of expression. This also gives the opportunity to those with secondary status in a community to learn more about PHC since they may be denied access to community meetings.

It is obvious yet important to state that all information for the public must be consistent. This requires careful planning and detailed briefing of all personnel involved in conveying information to communities, not only directly but through the mass media as well. One way of achieving this is for the national health authorities to publish details of proposals for PHC. Such a document can then be used as the official guide on all aspects of PHC implementation, including community involvement.

3.3 Conducting a dialogue with the community

At its highest level community involvement constitutes one half of a partnership of equals, the other half consisting of (usually) government personnel from health and related sectors outside the community. In order to achieve such a partnership it is not sufficient just to inform and educate communities about PHC and their roles in planning and implementing it. Rather there must be an exchange of information, of views and perspectives, whereby the people learn about PHC but also the "outsiders" learn about the people and their community. Such an exchange can only take place by means of a dialogue. In many instances this is not easy to achieve. Almost certainly several meetings may be necessary before the community and the outsiders feel sufficiently at ease with one another to be able to "converse" genuinely. Workers in the health sector have a particular difficulty in establishing a dialogue since their training often leads them to believe that they are in possession of special skill and knowledge which should entitle them to special status in society. This is an important reason for the inclusion of "communication with people" in preliminary training of health workers for their new roles in PHC.

CHAPTER 4: COMMUNITY ACTION IN PLANNING FOR PHC

"Upward planning and downward support is an ideal difficult to achieve... technical guidance and logistic support are inputs from above, peripheral levels must balance these inputs by taking initiatives in identifying needs, proposing strategies to fulfil the needs and taking part in carrying out these strategies. A reality in many developing programmes has been downward planning and implementation with little upward support. PHC is designed to counter such a reality and community participation is the mainstay of its success."

4.1 Assessing the state of the community

The process of community assessment, sometimes called community diagnosis, is critical for the following reasons:-

- it is an opportunity for the community to learn about itself,
- it is an opportunity for outsiders, such as health workers and personnel from other sectors, to learn about the community,
- it will generate information to be used for planning.

Ideally the process of community assessment should aim to find out all information relevant to the health and wellbeing of the entire community. It may not be possible to obtain such information at one time since neither the community nor the health workers may have sufficient time available to devote to data collection. Another important reason is that the community may not at first see the need for detailed collection of information. They may feel, with justification, that they know all there is to know by virtue of their day to day experiences. For this reason it may be a better approach to begin by asking the community, through its leaders, to describe its present circumstances in the following terms:-

WHO lives in the community?	- no. of households/families - no. of adults - male/female - no. of children - male/female - any special groups
WHERE do they live?	- geographical location of households
HOW do they live?	- source of income - source of food supply - rough income distribution
WHAT problems do they have?	- in general - health related
WHAT resources do they have?	- industrial/agricultural facilities - availability of essential commodities - schools - health facilities - water supply - sanitary facilities - access to main centres of population - roads/transport - access to radio/newspapers

All of this information can usually be obtained, at least roughly, through conversation. It should be recorded systematically, in writing, in terms that the people can understand and constantly refer to. Any gaps should be noted for future information gathering. This initial conversation is also a good means of assessing the knowledge of the leaders concerning their community which in turn is a useful indication of their interest or concern with the community as a whole.

At a later stage and before the commencement of systematic planning it will be necessary to supplement this information through a community survey, ideally on a house to house basis, and including the preparation of a community map. This exercise should be simple and quick and conducted with full community involvement in the collection and recording of data.

Where a community is large or time does not permit it may be necessary to compromise by collecting information from a proportion of households by means of a sample survey.

4.2 Identifying needs from the community perspective

The identification of needs as perceived by the community is a useful means of assessing the priorities and values of the people. As stated elsewhere it is quite possible that directly health related needs may not feature high on a list of overall community needs. In order to obtain such information it is important that the outsiders' enquiries about needs do not pressurize the community (inadvertently or otherwise) to include health needs which they do not consider important.

However it is also important to obtain the views of a representative cross section of the community since, for example, the needs as expressed by a well off farmer are likely to differ considerably from those of the wife of a poor labourer.

In eliciting felt needs a number of approaches are possible depending on the organizational structure adopted by the community for PHC.

Wherever there is a structure which has representation from all quarters of the community, that is, including women representatives of different socio-economic groups and minority representatives, then it may be possible to obtain valid responses through the type of discussion and "conversation" mentioned in 4.1 above.

In other cases an additional enquiry will usually be required, either as part of a community survey on all respect of the community or as a separate enquiry.

4.3 Specifying the priority health needs of the community

Specifying priority health needs is a delicate process requiring a lot of sensitivity on the part of the health worker who may be tempted to regard this as his particular field of expertise with the consequent danger of dictating to the people what their problems are. This must be resisted at all costs if genuine community involvement is to succeed.

On the other hand it is unrealistic and often undesirable to always expect health workers to accept outright the community's analysis of its own problems and needs. However, provided there has been a continuous dialogue throughout the community assessment process it will usually be feasible for a concensus to be reached between the community and the health worker as to what constitutes the major health problems.

4.4 Identifying community resources for tackling health problems

As discussed in Chapter 2, it is common in both traditional and modern societies for people to view health as an absence of disease and to regard action for better health as activities by health professionals in managing sickness whenever it occurs.

In such circumstances a considerable gap may exist between people's understanding of their health needs and the realization that better health can be achieved through their own efforts and by utilising their own resources. The gap may be even wider in some circumstances where the people are aware that the health facilities available to them are inferior to those available to others.

Thus although they may realize that using their own efforts may be effective they may regard such a measure as being unfair.

Any discussion concerning use of community resources for health will require considerable educational contributions by the health worker. He or she must be able to explain the causation of locally prevalent diseases in terms the community understands, as well as the relevance of prevention as opposed to treatment, factors involved in prevention and the role of the public as well as health workers in preventing specific diseases.

Responsibility for explaining the issue of fairness in relation to provision of health services and the distribution of national resources must lie with government at national level. Where unfairness exists the government should be prepared to state clearly how it intends to deal with the matter. The local level health workers should be in a position to offer the official explanation but the community may well expect reassurances from a higher level before they feel justified to invest their own resources.

When all of the above has been settled to the community's satisfaction it may be possible to proceed to identification of community resources for tackling health problems.

Examples of community resources and their mobilization for tackling health problems are discussed in Chapter 7.

4.5 Setting priorities for action

Setting priorities for action through PHC involves yet another process of discussing and weighing up a number of factors which include the community's felt needs in general, their perceived health needs, whether or not effective measures to tackle a problem actually exist, whether such measures are feasible in terms of acceptability to the community, in terms of cost and other resources such as time, and whether the measures fit in with priorities at intermediate and national levels.

Thus priorities may vary greatly, reflecting local judgement as far as possible. However it must be recognised that certain national health priorities will already have been established, for example with respect to immunisation and control of malaria, TB and STD. The health consequences for the country as a whole may be such that action cannot be postponed until all communities have explicitly endorsed the national programmes. Thus communities are likely to be faced with a number of health initiatives which are already being implemented without their approval being sought.

It will be important for the local health workers to explain the existence and relevance of such initiatives so that communities can incorporate them into their agreed priorities for action. However, in addition, there is a need for the health authorities at national level to become more aware of the importance of community action for health when planning programmes for immunisation and disease control.

4.6 Community needs in proportion to national capacity

Closely associated with the setting of priorities at community level is the capacity of the country as a whole to support their implementation. One striking example is the construction of a clinic or health centre which is a rather common community felt need. In almost every country in the world there are insufficient resources to finance such projects in every community taking into account not only the costs of construction but of training staff, paying their salaries and keeping them supplied with medicines and equipment. Even if it were possible the impact on health would be insignificant in the absence of other assets such as sufficient food, drinking water and sanitation.

In such circumstances where community felt needs cannot be met it is essential for the people to be informed as soon as possible to prevent feelings of disappointment and resentment from building up and to enable them to adjust their expectations to realistic levels. The onus should be on the national level to keep those at local level informed on this issue (via the intermediate level). Therefore a strong mechanism for flow of information will be required.

4.7 Mechanisms for intersectoral co-operation in planning for PHC

Intersectoral co-operation is one of the mainstays of the PHC approach.

> "No sector involved in community development can work effectively in isolation. Interdependence is such that activities in one sector have an impact on the goals of another.... For maximum benefit it is essential that all sectors fully appreciate their roles in overall community development and their relationships with one another. Thus there is an essential need for effective co-ordination at all levels between health and all other related sectors." (Report of the Alma Ata Conference).

At local level the mechanism established for community involvement will usually be adequate in providing for intersectoral co-operation, for example, the community development committee. Just like the local health worker, the role of the school teacher, the agricultural worker, the social worker, will be to act as a technical adviser to the community as well as provider of logistical support where appropriate.

Since local workers in the various development sectors will often require permission to commit their time, effort and resources in support of PHC it is essential that there are functioning mechanisms for intersectoral co-operation at intermediate and central levels. Without these mechanisms efforts at local level will be frustrated, ineffective and sooner or later will comprise a strong negative force acting against PHC development.

CHAPTER 5. POSSIBLE COMMUNITY ACTIONS FOR ACHIEVING BETTER HEALTH.

Primary health care starts at the level of the individual and family. Actions carried out at this level as well as at the collective community level have a great potential to bring about a marked improvement in the overall state of health of the peoples of all countries.

This chapter contains examples of actions which people can take in order to achieve better health. The contents are divided into two sections. The first is concerned with actions by individuals and families and the second with actions by communities or groups within communities.

5.1. Actions by the individual and family.

Actions for health by individuals and families may take the following forms:-

- adoption of a healthy lifestyle,
- actions intended to prevent specific diseases,
- diagnosis and treatment of illness when it occurs,
- appropriate use of available health services.

Of these the first two offer the greatest potential for achieving a significant and sustained improvement in health.

5.1.1 Healthy living.

Study of the causes of diseases which affect human beings has led to the identification of many risk factors which may be avoided by a change in living habits. For example, a major factor in ensuring a baby's proper start to life is the good general health of the mother during her pregnancy. Where the mother is well nourished it is much more likely that her baby will achieve good body development by the time of delivery. Conversely where she has a poor diet or adopts the habit of smoking cigarettes it is likely that she will give birth to a small baby whose life may be at risk from infections such as diarrhoea.

It is within people's power to limit or even avoid certain risks to their health by adopting a healthy lifestyle. It is better to start early. For example, the good nutrition of the child in the first four months or so after birth is assured by breast feeding. In addition the child will benefit from substances in breast milk which give protection against infections as well as the opportunity to form a close and loving relationship with the mother which breast feeding facilitates. By adopting breast feeding a mother can confer all these benefits on her child. Family members can play an important supportive role by ensuring that a mother has sufficient time to breast feed, by ensuring that she has sufficient good food to allow proper milk supply and by giving her encouragement to resist pressure, such as advertising, to adopt bottle feedings or cease breast feeding too early.

After the age of four months mothers should begin to give their babies portions of nutritious foods from the family diet in addition to breast milk. Apart from giving encouragement, families can contribute to good supplementary feeding of the baby, as well as to their own overall nutritional benefit, by cultivating a variety of nutritious crops, vegetables and fruit and by keeping livestock such as chickens for eating as well as to produce eggs.

Healthy living not only entails adopting behaviour which promotes the health of the body, such as good nutrition, but it is also concerned with behaviour which seeks to avoid or at least limit the effects of health hazards present in the community. Thus a balanced diet in sufficient quantities is good for the body. However its benefit may be destroyed unless people take action to protect their food and drinking water from contamination by germs which cause diarrhoea. Therefore good hygiene and sanitation go hand in hand with good nutrition.

For the individual good hygiene entails actions such as using a sanitary latrine for defaecation as well as maintaining good personal cleanliness by thoroughly washing hands after using the latrine, before preparing food and before eating.

For families good hygiene entails actions such as construction and maintenance of a sanitary latrine, and provision of adequate water to keep the household clean, with particular emphasis on drinking and eating utensils, on places where food and drinking water is stored and in the kitchen where meals are prepared. Other important actions are the boiling of drinking water and keeping the household and its surroundings clear of faeces, both human and animal, as a means of reducing the risk of diarrhoeal infections and worm infestations.

5.1.2 Prevention of specific diseases.

Certain diseases may present such a threat to the health of communities that special efforts are required by individuals and families to prevent their occurrence or at least reduce the frequency. In developing countries malaria is one of the most important widespread endemic diseases. Although action against malaria is required from the national health system the role of individuals and families in fighting the disease is also very important. Actions by individuals and families may take the following forms:-

- recognition of malaria symptoms and referral of the patient to the health centre or hospital for treatment;

- co-operation in national, regional or local efforts to control malaria, such as, co-operation in providing samples for blood slides, making sure that patients take their prescribed treatment or that high risk household members such as expectant mothers and under-fives take their preventive doses of medicine, co-operation in household spraying with residual insecticides.

- actions to prevent the breeding of anopheles mosquitoes by filling in any stagnant water pools on their land and by cutting down long grass and keeping the environment clean and free from rubbish.

- actions to prevent mosquitoes from biting, for example by putting mosquito proof materials over windows, doors and other entry points, by wearing clothes which cover the arms and legs at night and by repelling mosquitoes with smoke or certain leaves which may be locally available.

Another very important example is diarrhoea which is a major cause of death and sickness in many developing countries, particularly among infants and young children. Actions against diarrhoea in the home can have a dramatic impact both in terms of reducing the risk of occurrence of the disease and in reducing the rate of mortality when it does occur. Such actions should include the following:-

- recognition of the signs and symptoms of diarrhoea and the prompt starting of oral rehydration using appropriate fluids. Such fluids may take the form of salt and sugar mixed with boiled and cooled water or of specially prepared oral rehydration salts mixed with boiled and cooled water (for example the oral electrolyte salts produced by UNICEF). In addition research is currently being conducted into the possible use of household foods such as soups and ricewater for rehydration;

- recognition of the signs and symptoms of serious diarrhoea, particularly the signs of dehydration, and referral of the patient to the health centre or hospital for treatment;

- maintaining the nutrition of the patient with diarrhoea by encouraging him to eat his normal diet, if necessary divided into small amounts to be eaten frequently as opposed to normal quantities eaten at specified meal times;

- obtaining drinking water from a safe or protected source, using clean vessels for storing it and learning how to avoid water contamination.

- maintaining good hygienic standards in the home, particularly the washing of hands after defaecation, before preparing or handling food and before eating;

- breast-feeding of infants for as long as possible so that they benefit from the substances in the mother's milk which give protection against infection as well as the high overall nutritional value of human milk.

5.2 Community action.

All activities which individuals and families can take for better health should be undertaken by everyone in the community. This is not only because it is the most effective means of achieving the highest possible level of health for all, it is also because the failure by some individuals to participate may jeopardise the effectiveness of the actions of the remainder. For example one dirty household can provide a source from which infection can be transmitted to the others.

However there are additional actions which communities may usefully take either as a whole or through particular groups such as religious and voluntary organisations or local schools.

For an entire community the most important action is to agree what needs to be done, what is going to be done and who is going to do it. Otherwise communities as a whole can usually only work together intermittently when time permits. Such occasions may be used for actions such as clearing land for construction of a health centre or road, the making of bricks and transport of materials to a building site, digging of trenches for a piped water supply or clearing and tilling of land for the production of nutritious foods. Activities could be carried out on a regular, say weekly, basis until the particular project is completed.

However there may be additional groups within the community who are able and willing to undertake activities for the good of the community as a whole and for the benefit of a minority group such as the mentally handicapped who are unable to help themselves without assistance. Such groups may consist of members of religious or voluntary organisations. Just as importantly they may be members of women's or youth organisations affiliated to national non-governmental organisation or political parties. Local school children are another important example of groups who can take regular or even occasional action for the benefit of community health.

Such groups may involve themselves in a wide variety of activities including those mentioned above. An important additional activity is the education of the community as a whole about locally important health matters. They may be done on an individual household visiting basis, through the production of a newsletter or magazine, or through the organisation of public events such as exhibitions, drama and music performances which have an educational content.

Local schools can make a big contribution concerning education for better health not only through actions such as those above but by teaching the children how they in turn can educate their families at home.

"Learning by doing" is an effective educational technique. In turn the activities involved in learning can be channelled towards the improvement of community health. One common example of this is the school production unit in which pupils learn useful skills such as crop and vegetable production, keeping livestock, and making and maintaining tools. The pupils' products may then be shared in the community or on a more restricted basis such as providing food for nutritious school meals or meals for local hospitals.

A final example of community action for health deserves some emphasis since its relevance may not be readily apparent to the public. It is the collection of health and health related data.

Chapter 4 has stressed the importance of assessing community needs. Subsequent chapters will emphasise the importance of good management to ensure that available resources are properly distributed to meet needs. The key to completing these tasks effectively is comprehensive, up to date information. School children, or indeed members of any community groups, can play an extremely important role as collectors of information, preferably on a routine basis, in collaboration with the community health worker and the staff of the local health centre or hospital. The type of information to be collected will vary but country experiences show that such a method can be used for collecting information about births, deaths, incidence of sickness, nutrition surveillance, status of community sanitation and water supply, and immunization coverage.

By collecting and maintaining community health data not only will people provide the means for local health centre or hospital staff to organise health care more effectively but also they will come to know their own situation better and therefore identify their needs more accurately, agree on priorities and decide on the actions they must take to bring about an improvement in health.

CHAPTER 6: THE COMMUNITY HEALTH WORKER

In the worldwide debate on primary health care which has been going on since the Alma Ata Conference no single issue has provoked so much interest and even controversy as that of the community health worker.

There has also been a remarkable proliferation in the numbers of community health workers who have been trained and are now serving their communities. This chapter draws on experiences which many countries have gained through observation of the processes of selection, training and functioning of CHWs in an attempt to formulate guiding principles on the important issues related to the role of the CHW not just as a health worker but as the foremost example of community involvement in PHC.

6.1 The role of the Community Health Worker in PHC.

The CHW is much more than a health worker. He is also the epitome of community involvement in PHC. He represents the community and is responsible to it in carrying out his work, yet an important part of his responsibilities is to promote changes amongst the people which will result in better health. He is also a crucial link between the community and the health system. As such he can exert a crucial influence in helping the community and local health workers to reach a mutual understanding and respect thereby greatly enhancing the effectiveness of PHC.

Clearly the character and calibre of the CHW will contribute to the strength of the link. However no matter how good the CHW may be he will be unable to function effectively without strong support from the community on one side and the health system on the other. For example, poor community organization and inadequate community involvement in selecting the CHW will lead to a lack of support and trust. Similarly, infrequent supervisory visits by health personnel, or inadequate supplies of medicines to the CHW, will seriously impair his effectiveness.

The role of the CHW as a link is not only crucial to overall PHC organisation at local level, it also governs the success or failure of his other role, that of a health worker. In this role the CHW has the potential to help achieve the fundamental goal of PHC, that is, to make essential health care accessible to the entire population through a mixture of preventive, promotive and curative activities:

6.2 Selection of the CHW

Full community involvement is vitally important in the process of selecting the person who will be trained as the CHW. A number of country experiences offer support for this statement. For example in one country candidates for training were selected by a local religious leader without consulting the community who subsequently found them unacceptable. In another country it was decided to select CHWs from among people with previous experience as malaria eradication workers. They proved to be unsuitable because of an inability to gain the confidence of the people due ultimately to a lack of motivation.

The choice of a good candidate by the whole community depends on the people having a clear understanding of the role of the CHW and the tasks involved. Thus it is essential for local health workers to lay emphasis on this topic and to explain it carefully and fully when introducing PHC to the community.

In making their choice communities will usually wish to take into consideration the factors of age, sex and literacy.

As far as age is concerned many traditional societies respect the wisdom of the old much more than the energy and enthusiasm of the young. However, in addition, a number of countries have found in practice that mature, middle-aged men or women perform better than young people who also have a higher risk of dropping out of their CHW role.

The importance attached to the sex of a candidate will depend to a large extent on cultural preferences. In some communities there may be a demand for a female CHW to deal with female patients while a man may be preferred to undertake other tasks. This problem may be solved by training more than one CHW for a community, one of whom would be a woman. A traditional midwife could be one example.

The ability of candidates to read and write is an issue which may cause some difficulties. For example in many countries it is only the young who have had the opportunity to receive formal education and communities may feel that the person who is going to be their "doctor" should be literate resulting in selection of the CHW from amongst the young with the possibility of subsequent problems as described above. There is a greater risk of literacy influencing CHW selection in communities where the CHW's role is closely associated with the treatment of sickness and therefore with the use of medical technology. There is an additional risk that the local health workers may unduly influence the community to choose a literate candidate since they may feel that the prestige of health workers in general may suffer if an illiterate is chosen. It is a fact that illiterate people can be trained to acquire a lot of knowledge and skills. In some countries illiterate people have been selected and trained as CHWs. However the quality of their work in comparison with those of literate CHWs remains to be evaluated.

It is stating the obvious to say that a CHW should be present in his community as much as possible and preferably on a daily basis. Therefore it is important that the person selected to be the CHW appreciates the necessity to be available. In this connection a candidate's occupation may be an important factor, at least in those communities where the CHW is unpaid. In one country it was discovered after training that a number of CHWs were employed in jobs such as housebuilders which entailed leaving their communities for long periods thereby rendering them ineffective as CHWs.

6.3 Identifying priority activities for the CHW

The priority activities to be undertaken by the CHW will usually be closely related to the needs identified at part of community assessment and the priorities for action based on those needs, as described in Chapter 4. Therefore the wishes of the community will be of great importance although it will also be desirable for the advice of the local health centre staff to be respected so as to ensure a proper balance between preventive, promotive and curative aspects of health care in order to make possible a positive improvement in the overall health of the community.

However it is essential not only to identify what a CHW should do but also to assess what he can do. The latter will be determined by the following factors:

- the type and duration of his training,
- his level of overall education,
- health needs of the community,
- size of the population for which he is responsible and the size of the area over which they are distributed,
- the amount of time allocated by the CHW to his work (in agreement with the community)

When all of these factors have been considered a specific job description for each CHW can be drawn up in consultation with his community. During this process it may become evident that a CHW cannot do all that is needed or expected. The possibility of training another CHW or of allocating specific tasks to volunteers in the community may then be considered. One possibility is to train a local traditional midwife to be responsible for maternal and child health thus enabling the CHW to fulfil other duties.

6.4 Training of the CHW

It is logical to propose that the training given to a CHW should equip him with the knowledge and skills to fulfil all his functions, that is, as a link between the community and the health system, as a health worker carrying out preventive, promotive and curative

activities and as an agent of overall community development. This is a formidable task and one which requires careful planning and organisation of a training programme. The following factors are important in doing this effectively:-

Preparation of a CHW job description
The training curriculum
Duration of training
The quality of trainers
Teaching methods
Training venue.

6.4.1 Preparation of a CHW job description

The preparation of a CHW job description is a very important first step in formulating a full training curriculum. A good job description describes in detail the activities to be carried out. Therefore it must be based on the real life circumstances in local communities. It must allow for the variations which exist in problems and priorities between communities. It must be feasible in terms of the workload to be undertaken by the CHW. For these reasons both the community and local CHW trainers should be involved in preparing it.

6.4.2 The training curriculum

A CHW training curriculum should be related only to the activities he will undertake after training. Thus reference must be made to the CHW job description. This can then be used as a guide for formulating training objectives. These objectives will indicate the details of what the CHW must learn and this in turn can be used to develop learning materials and interesting activities, supported by appropriate teaching aids, which will promote learning.

6.4.3 Duration

The length of the training period is an important issue. The need to impart a lot of knowledge to the CHW must be weighed against the danger of separating him from his community for a long period thereby interfering with his relationship with the people. This problem can be overcome by dividing training into an initial period of perhaps one to three months followed by regular short periods of in-service training. This may be conducted by the CHW's supervisor, by short weekend or one week residential courses together with other CHWs or by a mixture of both.

6.4.4 The quality of trainers

Given the crucial role of CHWs it is important that their training should be of high quality whether it is conducted at special centres or at rural clinics. Thus the quality of the trainers and the preparation they receive for their training role are of the utmost importance.

Trainers may be full time or they may be health centre or district health staff for whom training is only one of several duties. The best approach may be to have a mixture of full time and part time trainers so that the CHWs may benefit from the training skills of the full time personnel whilst at the same time benefitting from the up-to-date practical experience of those who are part time.

It is important to pay attention to the selection of trainers to ensure that interest and ability to teach are the major criteria for selection. Country experiences to date indicate that there is a great shortage of specifically trained teachers for CHWs and that selection of trainers from among health personnel has been selected on the basis of availability rather than on aptitude, knowledge and motivation. This indicates that an important problem exists to which countries should give their urgent attention.

Apart from the personal qualities of trainers it is important that they should acquire all the following basic experience, knowledge and skills:-

- first hand experience of the situation in which CHWs will be working,
- knowledge of the CHWs job description, the training objectives and curriculum,
- knowledge of the tasks involved in organising a complete training course and an ability to manage the organization,
- an ability to teach, using different teaching methods and teaching aids, and to evaluate learning achievements.

6.4.5 Teaching methods

The methods used for teaching CHWs will govern to a great extent the amount of knowledge they absorb and retain. The ultimate training objective is for the CHWs to learn to do something. The most appropriate methods for achieving this are as follows:

- identification of problems in groups with sufficient time for discussion between the CHWs themselves and between the CHW and the trainer,
- demonstration and practising of skills,
- role-playing and case studies followed by group discussions.

In order to stimulate the process of learning each of these methods should be employed at different times so as to achieve variety as much as possible.

It should be noted that the most traditional teaching method, the lecture, is very poor as a means of teaching people to do something. Therefore the use of lectures in CHW training should be kept to a minimum.

6.4.6 Training Venue

The choice of where, how and when training takes place must be governed as far as possible by what has to be learned. Nevertheless the following factors should be considered when selecting a training venue.

Training centres are likely to promote learning best if they are situated away from any possible distraction. Thus centres in rural areas may be preferable to those in urban areas.

Otherwise the training venue should offer the best opportunity for the CHW to learn what is contained in their curriculum. In practice country experiences indicate that CHWs are being trained at a variety of venues such as national or regional training centres, hospitals or health centres, or in community centres. In addition most training programmes have a field training component which may either be in an organised field training site or in a nearby village. There are advantages and disadvantages to each option. For example, a special training centre may have the advantage of good teaching and living facilities. On the other hand, the use of such centres may limit the number of CHWs who can be trained and those who are trained may lose the benefit of learning within their own locality. They may also come to expect standards of living after training which are not available in field conditions.

In the same way decentralised training venues such as district offices or health centres may remove the disadvantages mentioned above but instead suffer from lack of skilled trainers, difficulties in supervision and poor facilities for learning, eating and sleeping.

As yet there is no perfect solution for the choice of training venue. However it is very probably that hospital based training is not appropriate for CHWs since it is extremely difficult to emphasise a preventive, community orientation in such a setting.

6.5 Community support for the CHW

The crucial importance of strong community support for the CHW has been emphasised in section 6.1 and underlines the need for the CHW to be a person respected and regarded as an equal by his community. However, in addition, tangible evidence of community support will usually be required if the CHW is to continue to carry out the difficult duties assigned to him. Such support may take the following forms:-

- participation in activities initiated by the CHW,
- provision of accommodation in which to examine patients and store medicines and records,
- provision and maintenance of transport such as a bicycle,
- intermittent or regular remuneration in cash or kind.

Of these different types of support the last is likely to be the most controversial because payment may introduce a number of negative consequences. These include complication of the selection of a CHW, interference with his subsequent selection of health priorities and ability to provide particular assistance for those most in need. In order to reach a solution mutually agreeable to the CHW and the community it is desirable that the issue of payment should be openly discussed within the community as part of the overall debate about primary health care. For the discussion to be meaningful the community must be fully acquainted with national policy on this issue, for example, whether responsibility for payment will rest entirely with communities or whether the government is prepared to contribute wholly or in part. The issue should also be specifically discussed when the community is selecting their CHW so that candidates can have a clear understanding of what to expect before they go for training.

If a community agrees to pay their CHW, the people must be aware of the consequences of their commitment. This will entail a discussion of whether to pay in cash or kind, whether to pay monthly or intermittently, and how the payment will be collected from the community. A mechanism for collecting, storing, paying the CHW and maintaining some kind of accounts must also be worked out. This could be a responsibility of the community committee.

However, country experiences show that even where there is complete agreement on the issue of payment when the CHW first started work there is a strong possibility that the issue will have to be rediscussed from time to time. For example the CHW may have underestimated the extent of his workload and therefore may wish to be paid more than initially agreed. From the community point of view people will wish to believe that the CHW's activities are directly benefitting them and, in addition, that their payments in cash and kind are being properly administered. This requires that the community has a thorough knowledge of primary health care right from the beginning of their involvement, that a system for monitoring PHC progress is included in the system at community level and that a proper, well organized and open accounting system in established (see Chapter 7).

CHAPTER 7: MOBILISATION OF COMMUNITY RESOURCES FOR PHC

Resources available for health care, particularly in developing countries, are limited. It follows that countries must strive to identify and then to mobilise all potential resources and ensure that they are used as effectively as possible.

Community involvement in PHC makes possible the mobilization of many resources which might otherwise remain unutilized.

7.1 Types of community resources

7.1.1 Action by the people

The individual and collective actions of the people constitute one of the most important types of community resources for achieving better health.

In addition to their involvement in identifying their health needs and planning overall PHC activities, referred to in previous chapters, there are many possibilities for action by the people. Examples include involvement in education programmes to increase knowledge about health, the use of simple technology to improve food preservation and storage, physical labour to construct a health centre, safe water well or sanitary latrine, provision of transport to take a woman in labour or a sick patient to hospital, organisation of a field day for immunisations and identification of children at risk.

Examples include, involvement in education programmes to increase knowledge about health, the use of simple technology to improve food preservation and storage, physical labour to construct a health centre or a safe water well, provision of transport to take a woman in labour or a sick patient to hospital, organisation of a field day for immunizations.

7.1.2 Provision of facilities

Communities may contribute facilities to be used for PHC activities. For example an existing building may be allocated for the CHW to treat patients and store his medicines and records. Other buildings may be contributed for educational purposes such as the holding of functional literacy classes or for use by local health centre or hospital staff when they visit to conduct field clinics and immunization sessions.

7.1.3 Provision of materials

Communities may contribute materials to be used for communal benefit. Examples are food such as grain, fruit and fish which could be used in cooking demonstrations, or for distribution to malnourished children, agricultural implements for use to boost community food production or building materials such as wood and bricks to be used in self-help construction schemes.

Certain individuals or groups may be able to make very special contributions. For example local traditional healers could provide some of their medicines for the benefit of the community as a whole in addition to those individuals who attend for personal consultations.

7.1.4 Money or contributions in lieu of money

Contributions of money or goods in lieu of money are obviously important types of resources. Examples of their use for PHC in communities are the purchase of medicines, the purchase of equipment such as agricultural implements for food production and payment of the CHW.

7.2 Mobilizing community resources

7.2.1 Community motivation

People will usually contribute their resources whenever they can foresee that the consequences will benefit them or their families. Therefore, whenever it is proposed to request contributions from the community, it is essential for the purpose of the contributions to be fully explained together with an explanation of the likely benefits. Since contributions will usually be expected from all who can afford it then it is important for everyone to have the opportunity to hear about a proposed activity, to know what contributions are required and for how long, to appreciate the nature of the anticipated benefits and to be able to discuss any misunderstandings or misgivings that may exist. The village pharmacy is an important example. An initial supply of medicines may be provided free of charge, either by the government or non-government organisation. Local people will then pay for the medicines they require and the money used by the community to replenish their stocks.

The commitment of resources may be required over a long period of time, for example to pay the CHW or regularly replenish the stocks of the village pharmacy. Thus it is very important to maintain the community's interest and motivation. This calls for the establishment of a system of monitoring the progress of the activities for which the people are contributing. Where the people are directly involved in a project such as construction of a drinking water system they can directly observe progress for themselves. However with other examples such as payment of the CHW the community will require to be regularly briefed, not only to know what is being done for their benefit but to know that their resources are being utilised in the way they intended. Thus the mobilisation of resources requires strong management to undertake the tasks of monitoring progress, informing the community, and accounting for the use of resources.

7.2.2 Managing resources

Responsibility for all stages of resource management will most obviously fall to the community development committee (or other group responsible for PHC). The stages include motivation of the people, collecting and storing the resources safely, allocating resources, monitoring the use of the resources, maintaining an accounting system and keeping the people informed.

The methods of collecting resources are many and varied, particularly where money is concerned. The following are examples:-

A) Curative services provided by the CHW

- fixed payment for each service provided,
- payment for each service depending on ability to pay,
- payment which varies according to the type of service provided,
- payment for drugs or a prescription which may vary according to the type of drug and/or the ability to pay,
- payment through an insurance scheme in which individuals or families make sustained periodic payments to provide for services when they are sick,
- donations for services, the amount depending on the ability or willingness of the patient.

B) All PHC activities

- payment through an insurance scheme covering community preventive and promotive activities as well as individual or family illness,
- periodic donations, for example, by the local co-operative,
- periodic fund raising campaigns which may include entertainment such as athletic or cultural activities organized by the community.

Whichever methods may be utilised it is essential for a secure and efficient accounting system to be established. This should be as open to public scrutiny as possible to ensure sustained confidence by the people. Responsibility for the accounting system may be assumed by the community committee as a whole, by a small sub-group or by an individual "treasurer." Such a task is demanding and, therefore, should be entrusted to a person or persons in whom the people have considerable confidence. A considerable constraint to the establishment of a proper accounting system will often be the lack of appropriate knowledge and expertise at community level. In such circumstances there will arise the possibility of intersectoral co-operation whereby the services of a suitably knowledgeable person such as a District Accountant may be obtained to give guidance and training.

7.3 Community Self-help Schemes

In many countries work schemes undertaken by communities on a self-help basis have made important contributions to development. Such schemes as part of community involvement in PHC have an important role to play in increasing and improving community resources for health. Apart from the construction of health facilities other possibilities include improvement of community housing, construction and maintenance of wells and boreholes to supply safe drinking water and the construction and maintenance of facilities for excreta and waste disposal.

The term "self-help" implies that a community takes complete responsibility for a project from planning through to implementation, including provision of all resources. In practice resources such as building materials and other equipment are often obtained from outside authorities, for example, at intermediate level. In order to ensure effective use of the community's resources it is essential for good co-operation to be established between the community and all relevant outside authorities beginning at the earliest stages of planning through to completion. In addition to resources for construction there may be further requirements when the scheme is completed. For example a new health centre will require staff, equipment and a continuous supply of medicines. Before the scheme even reaches the stage of construction it is essential to know whether or not such resources will be available and, if so, to ensure that they will be provided at the proper time.

Provided good co-ordination can be maintained a useful facility for improving the health of the community can be successfully completed with the possible additional benefit of stimulating further community involvement in PHC.

The contents of this chapter are intended to illustrate the possibilities and requirements for mobilising more resources for health. Although the emphasis is on the use of resources within communities one must not lose sight of the fact that communities are component parts of the country as a whole. The fact that people can mobilise more resources for health at community level does nothing to limit the fundamental need to redistribute overall national resources in order to achieve equity in accessibility to health care. Indeed it must be asked what resources the presently privileged members of society with free access to urban hospitals are going to make in order to match the efforts of their underprivileged countrymen.

CHAPTER 8: SUPPORT FOR THE COMMUNITY BY THE HEALTH SYSTEM

Strong support from the health system is an essential part of an effective PHC system. It is required from the health system at all levels but from the community point of view it is the support of the health worker at the local health centre or hospital which is of greatest importance. These local health workers are likely to be the people to introduce PHC to the community in the first place and they will certainly be involved closely in the continuing processes of informing, educating and guiding the community. They will also be the mainstay of support for the CHW by continuing his education, maintaining regular supervision, maintaining his supply of medicines, providing further treatment for his patients and, on occasion, acting as mediator in resolving problems which may arise with the rest of the community.

8.1 Integration of health services at the local level

In order to provide effective support for PHC there is a fundamental requirement for full integration of curative, preventive and promotive services at the level of the local health centre and hospital. Through integration it is possible to provide a comprehensive health service catering for local needs and priorities. Without integration there is likely to remain a system of care which is heavily curative oriented with some additional selective and fragmented preventive services such as immunisation and family planning.

The objective of integration should be to establish a system of health care which is responsible for the overall health of the local population and not merely for the treatment of those who become sick and are able to reach the services available at the health centre or hospital.

For example the doctor, nurse or medical assistant who is called upon to treat a child with a particular illness such as fever, diarrhoea or an injury must also assess the health of the child as a whole, especially his state of nutrition, rate of growth and immunization status. Similarly the health worker whose activities are based mainly in the community should focus attention on the health of the family and community as a whole rather than on selective issues such as the immunization status of the children or the family planning requirements of their mothers. More than that any problems detected must be acted upon personally or by contacting and discussing the issue with a colleague who has particular responsibility for taking appropriate action.

Without integration there is a serious risk that important health problems may be missed or overlooked. There is also a likelihood that the organization of services will be based on the wishes of the health workers rather than on the needs of the population. For example it is common in many countries to encounter health centres or hospitals which have a children's clinic one day and an antenatal or family planning clinic on another. The consequence is that the same mother and children must attend on both days since the mother and child, at least the young child, are inseparable. This is an obvious and unnecessary hardship which may cause the mother not to attend at all to the detriment of her own health or that of her child.

In order to achieve effective integration of services there are three main requirements:-

FIRST, the local health workers will require training to enable them to appreciate the need to broaden their responsibilities and to learn the skills to do so;

SECOND, the local health workers at both health centre and hospital must develop a team approach in carrying out their duties. This will entail the identification of specific tasks and responsibilities to be undertaken by each staff member in order to fulfil the functions necessary for implementing PHC. It will also entail the establishment of a mechanism such as regular team meetings in which each is encouraged to participate equally and through which they can co-ordinate their activities and find solutions to particular problems which may arise.

THIRD, there will often be a need to reorganize the services provided so that they are convenient for the local population and thus will encourage attendance. An example is the integration of mother and child clinics so that the needs of both can be met on one visit.

8.2 The health worker as educator

Education for PHC entails not only conventional health education of the public by creating an awareness and understanding of prevalent health problems and stimulating action by individuals, families and the community as a whole in terms of changes in behaviour and lifestyle. In addition it entails education of communities on the whole process of their involvement in PHC as principal actors in achieving better health as well as education of colleagues from other sectors of social development whose contributions are also essential.

The health worker from the local health centre or hospital is well placed to undertake this task since he is the member of the health system most familiar to the community through his role in treating or nursing the sick.

Unfortunately in many countries health workers are not well trained as educators. Therefore it will be essential to develop and conduct training courses in order to provide them with the necessary skills. Such courses should seek to give health workers an appreciation of the importance of the following:-

i. education which seeks to persuade people to adopt certain behaviour and lifestyle must stem from an initial understanding and sympathy for the values which govern their present attitudes and beliefs relating to health behaviour. Therefore health workers must learn how to know their communities;

ii. education for PHC is the top priority in achieving health for all. Therefore all health workers must be educators in addition to their other roles;

iii. good educators are good communicators. They are good listeners as well as talkers. Health workers should strive to encourage questions and comments from communities on all aspects of PHC.

By training health workers to be good educators not only will the knowledge of the community increase but it is likely that the relationship between the community and the health worker will be enhanced to the overall benefit of PHC.

8.3 Technical guidance to the community

This section is concerned with the quality of technical guidance to communities.

Chapter 5 contains examples of actions which communities may undertake in order to improve their health. The local health worker will be called upon to give technical guidance on the most effective way of planning, organizing and implementing such actions. Understandably the community will expect guidance to be given in a straightforward and authoritative manner. Such guidance may only require a few words delivered informally to an individual or may require a detailed briefing of a community development committee or overall community meeting. Obviously training as an educator will be of great benefit in making a good presentation.

However possible difficulties may arise in circumstances where there are different types of health worker attached to one institution. For example there may be a medical assistant who deals with examination of patients and diagnosis and treatment of illness. There may also be a nurse/midwife specialising in maternal and child health and family planning. In addition some health institutions will have a health assistant or sanitarian dealing with environmental health. In most countries it will be impossible for all of them to be present in a community at the same time. The possibility then arises of a particular health worker failing to have sufficient specialized knowledge to be able to guide the community on a particular issue with consequent damage to the credibility of the health worker and decrease in confidence and respect on the part of the community.

There are two possible ways of decreasing such risks. Firstly there is a strong case for including technical guidance to communities on all aspects of PHC as part of basic training of all health workers. For those already trained in-services courses can be used. Secondly there is a need for good team work amongst local level health workers. This should include regular meetings to exchange information on PHC development in their area of responsibility. In such a way it should be possible for each worker to broaden his knowledge as well as to identify areas of particular concern in particular communities and produce suitable guidelines for community action, the task being allocated to the worker with the appropriate knowledge.

8.4 Technical Supervision of the CHW

Continuous educative and regular supervision is indispensable to CHWs. Such supervision provides the CHW with reliable and valuable back-up and continuing education, strengthens his credibility in the community and his status as a health worker and member of the health team.

The task of supervision will often be one of the many duties of the local health centre or hospital worker. As such the points contained in sections 8.1 and 8.2 are also important in the context of CHW supervision.

However it is likely that difficulties will arise in maintaining regular supervision for the following reasons:-

- health centre or hospital staff may have heavy clinical and other responsibilities;

- some of these staff may be unsympathetic to community involvement in health care with consequently little motivation to maintain supervision,

- access to communities may be difficult due to long distances, difficult terrain and lack of transport.

One way of overcoming these difficulties may be to train other personnel specifically as CHW supervisors. These could include experienced CHWs with a good record of service.

8.5 Distribution of resources to the community

The types of resources which may be distributed to communities are usually rather few. They include medicines and supplies to the CHW, basic health education materials such as books, pamphlets, posters, sometimes transport such as bicycles, materials such as well liners, pans for latrines, pumps and spare parts for water supply and occasionally materials such as roofing sheets, door and window frames for self help construction schemes.

Responsibility for distribution lies mainly with staff at intermediate level. However in the case of drugs and supplies for the CHW and sometimes food supplements and oral rehydration salts for individual households the local health centre worker may be given responsibility. Therefore it is important for him to appreciate the following:-

- resources are almost always limited in quantity and it is necessary to distribute them in a rational and organised manner. For example supplies for CHWs could be divided according to the number of people each is responsible for;

- the rate at which resources, such as drugs, are used should be monitored and recorded, at least roughly, as a means of estimating future requirements and preventing wastage;

- communities should be made aware of what resources can be expected and for what specific purposes. Such awareness on the one hand can be useful in avoiding unrealistic expectations and on the other hand can help to mobilise community action in the event of supplies not being maintained.

8.6 The health centre worker as planner and manager

In many developing countries the network of health centres (or equivalent) forms the very backbone of the national health system. Thus the role of the health centre in PHC is crucially important. Apart from its conventional role of providing curative medical care it is also responsible for supporting and supervising the CHW as well as for guiding communities as a whole in their PHC activities. This support includes specifically the essential elements of PHC, such as nutrition and sanitation, which are included in Chapter 1.

In order to fulfil this central role in PHC effectively there will usually be an urgent need for the staff, such as medical assistant, nurse/midwife and sanitarian, to acquire new skills in planning and management. This will often entail an initial fundamental reorientation of their understanding of what their responsibilities are. They will need to appreciate that they are responsible for the health of a population rather than for treating the sickness of those who are able to reach them in their health centre building.

Examples of additional skills which they should learn include recording, maintaining and using of health information in order to identify the health problems of their population, the identification and management of resources such as money, medicines and their own working hours, setting priorities and formulating strategies for action, preparation of simple work programmes for specific periods of time, such as one month or one year and methods of evaluating the PHC activities within the area and populations for which they are responsible.

8.7 The role of the intermediate level

Increasingly experience from the many countries currently developing PHC shows that support from the local health system itself cannot be sustained without support from the level above - referred to as the intermediate level. This is the level at which most countries have introduced some form of local government or administration to take over many responsibilities from departments of central government. Its name varies from country to country. Examples are area, district, block, thana, municipality and commune.

The intermediate level is important for PHC for the following reasons:

- it is often the natural meeting point for "bottom-up" planning and organization and "top-down" planning and support, that is, where community needs and national priorities can be reconciled;

- it is small enough for problems and constraints at community level to be understood and for support for local health institutions to be co-ordinated;

- it is an administrative unit of government and therefore all the key development sectors are represented thus facilitating intersectoral co-operation.

Consequently a number of countries have designated this administrative unit as the basic unit for PHC organization. Thus PHC consists of all health related activities within the community, at the level of the local health institution, at the level of the first referral hospital up to and including the level of area management, that is, the intermediate level.

The principal skill of the intermediate level in support of PHC is good management particularly in the following activities:-

- organization and deployment of health system personnel;

- training of staff for PHC, including orientation of health workers for PHC, training of personnel from other sectors and, sometimes, training of CHWs;

- supervision of all health personnel;

- financing and budgeting to ensure proper allocation of funds for PHC;

- supply of medicines and equipment;

- supply and maintenance of transport;

- maintenance of building and equipment;

- organization of the mechanisms for referring patients.

In order to ensure the effectiveness of their actions intermediate level managers must have a personal knowledge of the situation in the area. To achieve this it is essential for them to make regular contact with communities, CHWs and local level health workers. They must also co-ordinate with other health agencies (where these exist) and with the managers of other development sectors. Responsibility for monitoring and evaluation of all PHC activities is an additional important task since comprehensive and up to date information is a basic requirement of good management.

8.8 The role of the District Hospital

In some countries the functions of the intermediate level described in Section 8.7 will be undertaken by staff based at the District Hospital whilst in others there may be a separate level of District planners and managers. Whichever the case the District Hospital is an essential component of the PHC system and will often undertake at least some of the following responsibilities:

- it will act as a health centre for the population within its immediate area of responsibility and thus will undertake the activities contained in Section 8.6;

- it will provide curative services for people living beyond reach of a health centre;

- it will be responsible for the organisation and supervision of all PHC activities beyond the areas of responsibility of health centres in the district;

- it will accept and serve patients referred from any health worker throughout the district as a whole.

In view of their important roles within the PHC system it is essential for the staff of the District Hospital to be included in courses for re-orientating and training local health workers such as those required to teach the skills specified in sections 8.2, 8.4 and 8.7.

CHAPTER 9: SUPPORT FOR PHC FROM THE NATIONAL LEVEL

The nature and extent of support from the national level will govern to a large extent the opportunities available at intermediate and local levels to make PHC effective.

The support may take the following forms:-

- political support
- administrative support, especially concerning the distribution of resources
- planning support.

9.1 Political support

PHC is a very important political issue since it is a component of overall socio-economic development and is particularly concerned with making essential health care accessible to all, with emphasis on the most needy. It is concerned with the rights of people to acquire a fair share of what is available. Thus it is concerned with justice, equity and the means to create them, principally the redistribution of resources.

It is clear that political activity is an essential ingredient in the furtherance of health for all by the year 2000.

The nature of political support will vary from country to country according to the nature of the political system. However, one important example could be the development of policies compatible with the PHC approach. Ideally these should not be confined only to the development of the health sector but to all aspects of national socio-economic development. Central to this issue will be policy governing the ways in which national resources, mainly in terms of money, will be distributed.

The extent to which governments are committed to such policies can be measured in terms of distribution of wealth throughout the population by means of income distribution and availability of services such as education, health and general social welfare benefits.

Commitment to health development itself can be judged by the proportion of the annual government budget allocated to the health sector and specific health activities in other sectors such as occupational health care in various industries.

However such a measurement does not reveal the way in which resources are distributed within the health sector. Conventional bias towards curative care through relatively sophisticated urban hospitals may mean that only a small proportion of a national health budget reaches the rural health institutions and the total allocation to preventive and promotive activities may be miniscule in relation to expenditure on curative services.

For these reasons a PHC oriented health policy should specify financial allocations within sectors as well as between sectors.

In most countries the total available resources will not match the total demand for shares in the distribution. This applies not only to demands by each sector but to demands within each sector as well. For this reason a lot of interest has focussed on the need to ensure political support through the establishment of a high level national body for health development where all issues concerning PHC and national development can be discussed. Such a body must be intersectoral and to have a direct link with central government in order to ensure appropriate executive action on its proposals and recommendations. These functions could be undertaken, for example, by a sub-committee of the cabinet, parliament as a whole or party central committee. Another possibility is the creation of a wider body such as a National Health Council which several countries have recently introduced.

Whatever the mechanism chosen at national level it is essential that it is linked with similar intersectoral bodies at intermediate and community levels to form a co-ordinated network for intersectoral action. The term National Health Development Network is applied to such a mechanism.

9.2 Administrative support

Unfortunately the fact that policies are created does not imply that they will be implemented. Successful implementation of PHC requires strong support by the Ministry of Health at national level. This can be manifested most strongly through the allocation of resources, swiftly and regularly, for use at the periphery by the health system at local level and by communities. Resources will include money for training such as health centre staff and community health workers, money for supplies such as fuel for transport and refrigerators, money for maintenance and repair of transport, equipment and buildings and money for staff salaries. Other resources will include additional health workers to serve the needs of communities, medicines and supply, transport such as bicycles, and even pens, paper and forms to maintain the health information system.

Unfortunately Ministries of Health at national level in many countries have a poor record in maintaining this kind of support. Often there is strong resistance by the powerful, such as urban based professionals, working in the major hospitals, against the transfer of resources to the periphery. Weakness or lack of will on the part of the Ministry may result in failure to overcome such resistance.

In addition the rules governing administrative procedures may be formulated in such a way as to minimise the risk of mishandling or loss of resources rather than to maximise the opportunities for staff at local level to function well. As a result the systems for releasing funds and accounting for their expenditure may be very cumbersome with the consequence that funds are seriously delayed in reaching the periphery.

This problem is often compounded by the character and calibre of officials working in national ministries whose knowledge of the circumstances at the periphery may be very limited and influenced by prejudices about the ability of health centre and other staff at local level to manage resources, particularly money.

Solutions to problems such as the above may be difficult to achieve. One possibility is to involve community representatives in the political control of health institutions at local and intermediate levels. In such a way defects in support from the national level can be identified early and action taken either by direct approach to the national ministry or via the political channels or both.

Another possibility is to train national level officials for their roles in support of PHC at community level.

9.3 Planning support

The need for upward planning and downward support has already been referred to in describing so-called "ideal conditions" for developing PHC. In such a way the felt needs as well as the assessed needs of the people can be properly represented, not only in terms of health but of overall community development. It is evident that the present reality is the opposite of the ideal. Planning in most countries takes place at the centre as opposed to the periphery and is conducted in isolation instead of being an integrated intersectoral exercise. Those involved are usually medical professionals focussing on health service programming and with few or no links with overall development planning. However increasing interest by countries in decentralisation offers an important opportunity for improvement in planning.

9.4 Research support

Many of the problems encountered in PHC implementation require careful study in order to identify appropriate solutions. For this reason national research institutions have a very important supporting role to play. Issues such as community organisation, the role of community health workers, intersectoral action, decentralisation of government administration and planning and management of health systems are only some of the important topics which require intensive study. These are topics which require the skilled attention not only of institutions for health research but also those devoted to the social sciences and overall development studies.

9.5 Decentralization of decision making

Decentralized decision making has gained widespread appeal in many countries in recent years. In the older established industrial countries there has been a voicing of public opinion in favour of a system which will give greater recognition to local variations in culture, such as customs and language and aspirations for future development. In many more recently established developing countries there has been a need to balance local aspirations against the overall stability and development of the nation in the face of grave economic difficulties. However, in these countries also, particularly the large ones, there is a lot of support for decentralization, although the need for central level control over distribution of national resources is recognized.

For the development of PHC, decentralization has the following advantages:-

- it makes it easier for communities to convey their needs and problems to the level of the decision makers who, hopefully, will include their representatives, that is, it facilitates community involvement;

- it speeds up the process of communication and thus facilitates the swift distribution of resources;

- it facilitates the development of plans in keeping with local needs and local variations in needs;

- it facilitates good intersectoral co-operation.

There are, of course, considerable difficulties to be overcome in creating an effective decentralized system of decision making. Some of these are as follows:-

- there is a risk that local demand may be beyond the national capacity to meet it. Therefore local leaders and administrators must be aware of what is feasible particularly in terms of resource allocation. For this reason many countries with decentralised systems maintain control of capital expenditure, for example, to build hospitals and clinics, at central level;

- there is a need for people with appropriate training and skill to undertake necessary financial management and accounting at local level. In many developing countries decentralisation is seriously impeded by a shortage of trained personnel who are willing to work outside the urban areas;

- in the same way there is a need for skilled planners and managers of the health system. The shortage of available skilled personnel will require the setting up of training facilities which may be costly and take time to complete.

As a result of all or some of the above there may be a need to phase decentralization over a number of years. Thus, for PHC the "ideal" circumstances of bottom-up planning and management coupled with top-down support may not be reached for some time. This places an additional obligation on the existing central level system to provide its support in a sensitive and whole-hearted manner.

CHAPTER 10: MAINTAINING EFFECTIVE COMMUNITY ORGANIZATION

If a community values PHC then the people themselves will maintain good community organization. The extent to which they value PHC will depend largely on how successfully their health needs are being met, particularly those needs to which they attach greatest importance. However very obvious improvements in health usually require a number of years to achieve. Therefore short term improvements may be difficult to perceive. In order to maintain the interest and enthusiasm of the community, and thereby ensure good community organization, it is essential to undertake the continuous task of informing and educating the people so that they are aware of the changes taking place albeit gradually and how such changes constitute steps leading to the ultimate achievement of health for all.

10.1 Keeping the community informed

The process of setting priorities for action by the community will often involve a compromise between what the people want, for example a new health centre, and what the health system through the local health centre staff believes they need in order to achieve a lasting improvement in health (see Chapter 4).

For people to continue to value PHC they must continue to agree with the priorities for action. Health education which seeks to explain the relevance of preventive and promotive activities as well as the long-term nature of health development is an essential means of promoting agreement. However, in addition people also need to see some positive results from their activities. This can be done by keeping them regularly informed of how their actions in the short-term contribute to the attainment of longer term goals and how their achievements as a community compare with those of other communities in their locality.

Possible mechanisms for doing this are as follows:-

(i) Regular reporting of all PHC activities at meetings of the community development committee and meetings of the entire community.

(ii) Regular reporting of PHC activities to individual families by the CHW during household visits. This can have the added advantage of making each family aware of how its own activities compare with the community as a whole.

(iii) Regular publication of a community "newspaper" which may consist of a blackboard with handwritten information situated at some public place, handwritten or printed wall posters or a printed newsletter distributed to individual households.

(iv) Regular publication of a newspaper covering a wider population such as the district or even the nation as a whole. By publicising activities by specific communities a feeling of pride can be generated - a very strong positive force for community organisation.

(v) Inclusion of items of PHC news in the mass media - newspapers, radio and sometimes television.

10.2 Keeping the health system informed - monitoring and evaluation of PHC

Monitoring refers to the process of routinely assessing progress in PHC development, for example, by noting the completion of specific activities during a relatively short period of time, such as the number of community development committee meetings held during the past month, or the number of children immunised during the past month.

Evaluation refers to the process of measuring the extent to which a PHC programme achieves its objectives. Objectives may be expressed in terms such as reduction of the infant mortality rate, reduction of the numbers of cases of a specific disease, increase in the number of mothers receiving regular antenatal care, increase in the number of protected water wells.

Thus monitoring refers more to "keeping an eye" on day to day progress whilst evaluation is a more formal process of measuring achievement and tends to be carried out at longer intervals such as every year or every two years.

Both monitoring and evaluation are essential parts of any health system since they provide those responsible for planning and management at all levels with the information necessary to make rational decisions. For example they enable decision makers to identify areas of greatest need, establish rational priorities and allocate resources to meet the needs effectively.

It is important to include all components of PHC in the monitoring and evaluation processes. Thus, information on the nature and extent of community involvement, the strength of community organization, the nature and extent of intersectoral co-operation, should all be included, in addition to details of the activities involved in implementing PHC elements, such as, health education, nutrition. The performance of the health system itself is an essential part of the processes.

The total information required to carry out an evaluation is detailed and lengthy and is not included in this chapter. However it is essential for communities and local level health workers to appreciate the importance of monitoring and evaluation and to become involved in the routine recording of data. Initially these processes may be conducted by the staff at intermediate level and above but eventually training, particularly of the local health centre workers, should include monitoring and evaluation in order to build up their skills in management.

Finally the importance of a two-way flow of information needs to be emphasised. Information being regularly recorded and passed from the levels of the community and local health institutions must be matched by a corresponding flow of information in the reverse direction. This could take the form of technical guidance to the community about certain disease problems, or information about the community's needs and their PHC activities in relation to other communities. It could also include information about resource allocation which is extremely important as an indication of the support they receive from the health system and has a vital bearing on the functioning of the CHW as well as overall community organisation for PHC.

At a more fundamental level the feedback of information can even be regarded as a matter of courtesy. The routine recording of information is a time-consuming and often tedious process. Regular feedback can make the process rewarding instead of futile and may be very helpful in building a relationship (albeit distant) between communities, their colleagues at local health institutions and the higher levels of the national health system.

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